ASSEMBLY BILL NO. 408–ASSEMBLYMEN JOINER, SPIEGEL, BILBRAY-AXELROD, FUMO, SPRINKLE; ARAUJO, BENITEZ-THOMPSON, BROOKS, BUSTAMANTE ADAMS, CARLTON, CARRILLO, COHEN, DALY, DIAZ, FLORES, FRIERSON, MCCURDY II, MONROE-MORENO, NEAL, OHRENSCHALL, SWANK AND THOMPSON

MARCH 20, 2017

Referred to Committee on Health and Human Services

SUMMARY—Revises provisions relating to Medicaid and health insurance. (BDR 38-957)

FISCAL NOTE: Effect on Local Government: May have Fiscal Impact.
Effect on the State: Yes.

CONTAINS UNFUNDED MANDATE (§ 9)
(NOT REQUESTED BY AFFECTED LOCAL GOVERNMENT)

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EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets [~~omitted material~~] is material to be omitted.

AN ACT relating to health care; requiring the State Plan for Medicaid to cover certain preventive health care services and maternity and newborn care; revising provisions relating to the dispensing of contraceptives; requiring insurers to offer health insurance coverage regardless of the health status of a person; requiring insurers to allow the covered adult child of an insured to remain covered by the health insurance of the insured until 26 years of age; requiring insurers to provide coverage for certain family planning services and supplies and preventive health care services for women, adults and children at no cost; requiring insurers to provide coverage for maternity and newborn care; prohibiting providers of health care and insurers from discriminating against a person on certain grounds; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Existing law provides that an insurer may not deny, limit or exclude a benefit provided by a health care plan in certain limited circumstances, including, without limitation, when a person has contracted for a blanket policy of accident or health insurance or in certain cases relating to adoption. (NRS 689B.500, 689C.190, 695A.159, 695B.193, 695C.173, 695F.480) The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits an insurer from establishing rules for eligibility for a health care plan based on sex or certain health status factors, including, without limitation, preexisting conditions, claims history or genetic information, and also prohibits an insurer from charging a higher premium, deductible or copay based on sex or these health status factors. (42 U.S.C. § 300gg-4) **Sections 15, 31, 41, 48, 57, 68, 80, 83 and 94** of this bill align Nevada law with federal law and require all insurers to offer health insurance coverage regardless of the health status of a person and prohibits an insurer from denying, limiting or excluding a benefit or requiring an insured to pay a higher premium, deductible, coinsurance or copay based on the health status of the insured or the covered spouse or dependent of the insured.

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires all insurers to extend coverage for the covered adult child of an insured until such child reaches 26 years of age. (42 U.S.C. § 300gg-14) **Sections 16, 25, 34, 49, 58, 69, 81 and 84** of this bill align Nevada law with federal law in this manner.

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires all health insurance plans to include coverage for maternity and newborn care. (42 U.S.C. § 18022(b)) **Sections 21, 32, 43, 53, 62, 73 and 88** of this bill align Nevada law with federal law in this manner.

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) requires all health insurance plans to include coverage, without any higher deductible or any copay or coinsurance, for certain preventive health care services for women, adults and children, including, without limitation, screenings and tests for certain diseases, counseling, contraceptive and other family planning drugs, devices and services as well as vaccinations. (42 U.S.C. § 300gg-13; 45 C.F.R. § 147.130) **Sections 9-10, 16.5-20, 22, 25.5-30, 34.5-39, 49.5-52, 54, 55, 58.5-61, 63, 64, 69.5-72, 76, 77, 84.5-87, 89 and 90** of this bill align Nevada law with federal law in this manner, and extend these requirements to health insurance purchased by local governments and the Public Employees' Benefits Program. **Sections 1.5-4, 5.5, 6 and 7** of this bill also require the State Plan for Medicaid to include certain preventive health care services for women, adults and children.

Existing law allows an insurer which is affiliated with a religious organization and which objects on religious grounds to providing coverage for contraceptive drugs and devices to exclude coverage in its policies, plans or contracts for such drugs and devices. (NRS 689A.0415, 689B.0376, 695B.1916, 695C.1694) **Sections 16.5, 20.3, 20.6, 25.5, 30.3, 30.6, 58.5, 63.3, 63.6, 69.5, 74.3 and 74.6** of this bill move the religious exemption coverage for the contraceptive drugs, devices and services required by this bill to the new provisions relating to coverage of contraception. **Sections 34.5, 49.5 and 84.5** of this bill provide a religious exemption for insurers who are newly required by this bill to provide coverage of drugs and devices for contraception.

Existing law authorizes a pharmacist to dispense up to a 90-day supply of a drug pursuant to a valid prescription or order in certain circumstances. (NRS 639.2396) **Section 11.3** of this bill requires a pharmacist to dispense up to a 12-month supply of a drug for contraception or a therapeutic equivalent pursuant to a valid prescription or order if: (1) the patient has previously received a 3-month supply of the same drug; (2) the patient has previously received a 9-month supply of the same drug or a supply of the same drug for the balance of the plan year in

which the 3-month supply was prescribed or ordered, whichever is less; (3) the patient is insured by the same health insurance plan; and (4) a provider of health care has not specified in the prescription or order that a different supply of the drug is necessary.

The Patient Protection and Affordable Care Act (Public Law 111-148, as amended) prohibits a provider of health care or state health insurance exchange who receives federal money from discriminating against a person on the basis of race, color, national origin, sex, age, or disability in providing health care services to the person. The Act also prohibits an insurer who receives federal money from discriminating against a person on those same grounds, as well as gender identity or expression. (42 U.S.C. § 18116; 45 C.F.R. § 92.207) The federal regulation that prohibits insurers from discriminating on the basis of gender identity or expression is no longer enforceable, however, because it was recently held to exceed the statutory authority granted by the Act. (*Franciscan Alliance Inc., v. Burwell*, 2016 WL 7638311 (N.D. Tex. Dec. 31, 2016)) Federal regulations also require providers of health care, state health insurance exchanges and insurers to provide certain assistive services and notice of these nondiscrimination provisions to all persons who receive health care services. (45 C.F.R. §§ 92.8, 92.201, 92.202) **Sections 11 and 12** of this bill generally align Nevada law with federal law, and prohibit a provider of health care or an insurer from discriminating against a person on these grounds, including, without limitation, discrimination based on gender identity or expression or sexual orientation.

WHEREAS, Passage of the Patient Protection and Affordable Care Act, Public Law 111-148, as amended by Congress in 2010, granted all Nevadans certain rights relating to health insurance coverage and provided greater access to health care benefits in this State; and

WHEREAS, Congress currently is considering the repeal of the Patient Protection and Affordable Care Act; and

WHEREAS, The Nevada Legislature wishes to ensure that all Nevadans continue to have access to certain rights and health care benefits currently guaranteed by the Patient Protection and Affordable Care Act; and

WHEREAS, The Nevada Legislature intends to maintain, not expand, those rights and health care benefits as they existed on January 1, 2017; now, therefore,

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 422 of NRS is hereby amended by adding thereto the provisions set forth as sections 1.5 to 6, inclusive, of this act.

Sec. 1.5. ***1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures for family planning services and supplies, including, without limitation:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered; and

(2) Approved by the Food and Drug Administration;

(c) Insertion or removal of a device for contraception;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. Except as otherwise provided in subsections 4 and 5, to obtain any benefit included in the Plan pursuant to subsection 1, a person enrolled in Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. The Director shall ensure that the provisions of this section are carried out in a manner which complies with the requirements established by the Drug Use Review Board and set forth in the list of preferred prescription drugs established by the Department pursuant to NRS 422.4025.

4. The Plan may require a person enrolled in Medicaid to pay a higher deductible, copayment or coinsurance for a drug for contraception if the person refuses to accept a therapeutic equivalent of the drug.

5. For each method of contraception which is approved by the Food and Drug Administration, the Plan must include at least one drug or device for contraception for which no deductible, copayment or coinsurance may be charged to the person enrolled in Medicaid, but the Plan may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

6. As used in this section, "therapeutic equivalent" means a drug which:

(a) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(b) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(c) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 2. *1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:*

(a) Counseling and support for breastfeeding;

(b) Screening and counseling for interpersonal and domestic violence;

(c) Counseling for sexually transmitted diseases;

(d) Screening for blood pressure abnormalities and diabetes, including gestational diabetes;

(e) An annual screening for cervical cancer;

(f) Screening for depression;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

Sec. 3. *1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring

cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between the ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between the ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

3. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

Sec. 4. *1. The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:*

(a) Screening for depression;

(b) Smoking cessation programs;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age;

(d) Assessments relating to height, weight, body mass index and medical history of persons less than 18 years of age; and

(e) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization.

2. To obtain any benefit provided in the Plan pursuant to subsection 1, a recipient of Medicaid must not be required to:

(a) Pay a higher deductible, any copayment or coinsurance; or

(b) Be subject to a longer waiting period or any other condition.

Sec. 5. (Deleted by amendment.)

Sec. 5.5. *The Director may include in the State Plan for Medicaid a requirement that, to the extent money is available, the State pay the nonfederal share of expenditures incurred for:*

1. Supplies for breastfeeding; and

2. Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization.

Sec. 6. *The Director shall include in the State Plan for Medicaid a requirement that the State pay the nonfederal share of expenditures incurred for:*

1. A mammogram;

2. Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

3. Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

Sec. 7. NRS 422.2718 is hereby amended to read as follows:

422.2718 1. The Director shall include in the State Plan for Medicaid a requirement that the State shall pay the nonfederal share of expenses incurred for ~~[administering]~~ ***:***

(a) Testing for human papillomavirus; and

(b) Administering the human papillomavirus vaccine ~~[to women and girls]~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration to be used for the prevention of human papillomavirus infection and cervical cancer.

Sec. 7.5. NRS 422.401 is hereby amended to read as follows:

422.401 As used in NRS 422.401 to 422.406, inclusive, ***and section 1.5 of this act,*** unless the context otherwise requires, the words and terms defined in NRS 422.4015 and 422.402 have the meanings ascribed to them in those sections.

Sec. 8. NRS 422.403 is hereby amended to read as follows:

422.403 1. ~~[The]~~ ***Except as otherwise provided in NRS 422.2718, the*** Department shall, by regulation, establish and manage the use by the Medicaid program of step therapy and prior authorization for prescription drugs.

2. ~~[The]~~ ***Except as otherwise provided in NRS 422.2718, the*** Drug Use Review Board shall:

(a) Advise the Department concerning the use by the Medicaid program of step therapy and prior authorization for prescription drugs;

(b) Develop step therapy protocols and prior authorization policies and procedures for use by the Medicaid program for prescription drugs; and

(c) Review and approve, based on clinical evidence and best clinical practice guidelines and without consideration of the cost of the prescription drugs being considered, step therapy protocols used by the Medicaid program for prescription drugs.

3. The Department shall not require the Drug Use Review Board to develop, review or approve prior authorization policies or procedures necessary for the operation of the list of preferred prescription drugs developed for the Medicaid program pursuant to NRS 422.4025.

4. The Department shall accept recommendations from the Drug Use Review Board as the basis for developing or revising step

therapy protocols and prior authorization policies and procedures used by the Medicaid program for prescription drugs.

Sec. 9. NRS 287.010 is hereby amended to read as follows:

287.010 1. The governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada may:

(a) Adopt and carry into effect a system of group life, accident or health insurance, or any combination thereof, for the benefit of its officers and employees, and the dependents of officers and employees who elect to accept the insurance and who, where necessary, have authorized the governing body to make deductions from their compensation for the payment of premiums on the insurance.

(b) Purchase group policies of life, accident or health insurance, or any combination thereof, for the benefit of such officers and employees, and the dependents of such officers and employees, as have authorized the purchase, from insurance companies authorized to transact the business of such insurance in the State of Nevada, and, where necessary, deduct from the compensation of officers and employees the premiums upon insurance and pay the deductions upon the premiums.

(c) Provide group life, accident or health coverage through a self-insurance reserve fund and, where necessary, deduct contributions to the maintenance of the fund from the compensation of officers and employees and pay the deductions into the fund. The money accumulated for this purpose through deductions from the compensation of officers and employees and contributions of the governing body must be maintained as an internal service fund as defined by NRS 354.543. The money must be deposited in a state or national bank or credit union authorized to transact business in the State of Nevada. Any independent administrator of a fund created under this section is subject to the licensing requirements of chapter 683A of NRS, and must be a resident of this State. Any contract with an independent administrator must be approved by the Commissioner of Insurance as to the reasonableness of administrative charges in relation to contributions collected and benefits provided. The provisions of NRS 687B.408, 689B.030 to 689B.050, inclusive, ***and sections 25 to 28, inclusive, of this act*** and 689B.287 ***and 689B.500 and 689B.520*** apply to coverage provided pursuant to this paragraph ~~[.]~~ ***, except that the provisions of NRS 689B.500 and 689B.520 and sections 25 to 28, inclusive, of this act only apply to coverage for active officers and employees of the governing body or the dependents of such officers and employees.***

(d) Defray part or all of the cost of maintenance of a self-insurance fund or of the premiums upon insurance. The money for contributions must be budgeted for in accordance with the laws governing the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada.

2. If a school district offers group insurance to its officers and employees pursuant to this section, members of the board of trustees of the school district must not be excluded from participating in the group insurance. If the amount of the deductions from compensation required to pay for the group insurance exceeds the compensation to which a trustee is entitled, the difference must be paid by the trustee.

3. In any county in which a legal services organization exists, the governing body of the county, or of any school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada in the county, may enter into a contract with the legal services organization pursuant to which the officers and employees of the legal services organization, and the dependents of those officers and employees, are eligible for any life, accident or health insurance provided pursuant to this section to the officers and employees, and the dependents of the officers and employees, of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency.

4. If a contract is entered into pursuant to subsection 3, the officers and employees of the legal services organization:

(a) Shall be deemed, solely for the purposes of this section, to be officers and employees of the county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency with which the legal services organization has contracted; and

(b) Must be required by the contract to pay the premiums or contributions for all insurance which they elect to accept or of which they authorize the purchase.

5. A contract that is entered into pursuant to subsection 3:

(a) Must be submitted to the Commissioner of Insurance for approval not less than 30 days before the date on which the contract is to become effective.

(b) Does not become effective unless approved by the Commissioner.

(c) Shall be deemed to be approved if not disapproved by the Commissioner within 30 days after its submission.

6. As used in this section, "legal services organization" means an organization that operates a program for legal aid and receives money pursuant to NRS 19.031.

Sec. 9.5. NRS 287.0272 is hereby amended to read as follows:

287.0272 1. If the governing body of any county, school district, municipal corporation, political subdivision, public corporation or other local governmental agency of the State of Nevada provides health insurance through a plan of self-insurance, the plan must provide coverage for benefits payable for expenses incurred for administering the human papillomavirus vaccine ~~[to women and girls]~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. The plan of self-insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.

3. A plan of self-insurance described in subsection 1 which is delivered, issued for delivery or renewed on or after July 1, 2007, has the legal effect of including the coverage required by subsection 1, and any provision of the plan which is in conflict with subsection 1 is void.

4. For the purposes of this section, "human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

Sec. 10. NRS 287.04335 is hereby amended to read as follows:

287.04335 If the Board provides health insurance through a plan of self-insurance, it shall comply with the provisions of NRS 689B.255, 695G.150, 695G.160, 695G.162, 695G.164, 695G.1645, 695G.1665, 695G.167, 695G.170 to 695G.173, inclusive, 695G.177, 695G.200 to 695G.230, inclusive, 695G.241 to 695G.310, inclusive, and 695G.405, ***and sections 83 to 89, inclusive, of this act,*** in the same manner as an insurer that is licensed pursuant to title 57 of NRS is required to comply with those provisions.

Sec. 11. Chapter 629 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, a provider of health care shall not discriminate in providing a health care service to a person on the basis of race, color, national origin, sex, age, physical or mental disability, sexual orientation or gender identity or expression.

2. A provider of health care may make distinctions in providing health care services based on sex or gender identity or expression if the provider has an exceedingly persuasive

justification for the distinction, which may include, without limitation, that the distinction is substantially related to the achievement of an important health or scientific objective.

3. A provider of health care must provide reasonable notice to a person who receives health care services relating to the provisions of this section.

4. A provider of health care must take reasonable steps to ensure that a person with limited English proficiency or physical or mental disabilities who receives health care services from the provider has access to any assistance services which may be needed for the person to communicate effectively with the provider.

5. As used in this section:

(a) "Gender identity or expression" has the meaning ascribed to it in NRS 193.0148.

(b) "Health care service" means the care and observation of patients, the diagnosis of human diseases, the treatment and rehabilitation of patients, or related services.

(c) "Sexual orientation" has the meaning ascribed to it in NRS 118.093.

Sec. 11.3. Chapter 639 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsections 2 and 3, pursuant to a valid prescription or order for a drug to be used for contraception or its therapeutic equivalent which has been approved by the Food and Drug Administration a pharmacist shall:

(a) The first time dispensing the drug or therapeutic equivalent to the patient, dispense up to a 3-month supply of the drug or therapeutic equivalent.

(b) The second time dispensing the drug or therapeutic equivalent to the patient, dispense up to a 9-month supply of the drug or therapeutic equivalent, or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.

(c) For a refill in a plan year following the initial dispensing of a drug or therapeutic equivalent pursuant to paragraphs (a) and (b), dispense up to a 12-month supply of the drug or therapeutic equivalent or any amount which covers the remainder of the plan year if the patient is covered by a health care plan, whichever is less.

2. The provisions of paragraphs (b) and (c) of subsection 1 only apply if:

(a) The drug for contraception or the therapeutic equivalent of such drug is the same drug or therapeutic equivalent which was

previously prescribed or ordered pursuant to paragraph (a) of subsection 1; and

(b) The patient is covered by the same health care plan.

3. If a prescription or order for a drug for contraception or its therapeutic equivalent limits the dispensing of the drug or therapeutic equivalent to a quantity which is less than the amount otherwise authorized to be dispensed pursuant to subsection 1, the pharmacist must dispense the drug or therapeutic equivalent in accordance with the quantity specified in the prescription or order.

4. As used in this section:

(a) "Health care plan" means a policy, contract, certificate or agreement offered or issued by an insurer, including without limitation, the State Plan for Medicaid, to provide, deliver, arrange for, pay for or reimburse any of the costs of health care services.

(b) "Plan year" means the year designated in the evidence of coverage of a health care plan in which a person is covered by such plan.

(c) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 11.6. NRS 639.2396 is hereby amended to read as follows:

639.2396 1. Except as otherwise provided by subsection 2, a prescription which bears specific authorization to refill, given by the prescribing practitioner at the time he or she issued the original prescription, or a prescription which bears authorization permitting the pharmacist to refill the prescription as needed by the patient, may be refilled for the number of times authorized or for the period authorized if it was refilled in accordance with the number of doses ordered and the directions for use.

2. ~~[A]~~ ***Except as otherwise provided in section 11.3 of this act, a*** pharmacist may, in his or her professional judgment and pursuant to a valid prescription that specifies an initial amount of less than a 90-day supply of a drug other than a controlled substance followed by periodic refills of the initial amount of the drug, dispense not more than a 90-day supply of the drug if:

(a) The patient has used an initial 30-day supply of the drug or the drug has previously been prescribed to the patient in a 90-day supply;

(b) The total number of dosage units that are dispensed pursuant to the prescription does not exceed the total number of dosage units, including refills, that are authorized on the prescription by the prescribing practitioner; and

(c) The prescribing practitioner has not specified on the prescription that dispensing the prescription in an initial amount of less than a 90-day supply followed by periodic refills of the initial amount of the drug is medically necessary.

3. Nothing in this section shall be construed to alter the coverage provided under any contract or policy of health insurance, health plan or program or other agreement arrangement that provides health coverage.

Sec. 12. Chapter 679A of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 2, an insurer who offers a policy of health insurance shall not refuse to provide coverage to or discriminate against a person based on race, color, national origin, sex, age, physical or mental disability, sexual orientation or gender identity or expression. Such discriminatory actions include, without limitation:

(a) Cancelling a policy;

(b) Refusing to provide a benefit which is available under a policy to other similarly situated persons;

(c) Limiting coverage of a claim; or

(d) Imposing an additional deductible, premium, copay, coinsurance or any other limitation or restriction on coverage.

2. An insurer may include distinctions in a policy of health insurance based on sex or gender identity or expression if the insurer has an exceedingly persuasive justification for the distinction, which may include, without limitation, that the distinction is substantially related to the achievement of an important health or scientific objective.

3. An insurer must provide reasonable notice to an insured relating to the provisions of this section.

4. An insurer must take reasonable steps to ensure that an insured with limited English proficiency or physical or mental disabilities has access to any assistance services which may be needed for the insured to communicate effectively with the insurer.

5. Nothing in this section may be construed as preventing an insurer from determining whether a benefit is medically necessary or whether any such benefit meets any other requirement for coverage included in a policy of health insurance which is not prohibited by this section or any other provision of law.

6. As used in this section:

(a) "Gender identity or expression" has the meaning ascribed to it in NRS 193.0148.

(b) "Sexual orientation" has the meaning ascribed to it in NRS 118.093.

Sec. 13. NRS 687B.225 is hereby amended to read as follows:

687B.225 1. Except as otherwise provided in NRS 689A.0405, 689A.0413, 689A.044, 689A.0445, 689B.031, 689B.0313, 689B.0317, 689B.0374, 695B.1912, 695B.1914, 695B.1925, 695B.1942, 695C.1713, 695C.1735, 695C.1745, 695C.1751, 695G.170, 695G.171 and 695G.177, ***and sections 38, 39, 54, 55 and 89 of this act,*** any contract for group, blanket or individual health insurance or any contract by a nonprofit hospital, medical or dental service corporation or organization for dental care which provides for payment of a certain part of medical or dental care may require the insured or member to obtain prior authorization for that care from the insurer or organization. The insurer or organization shall:

(a) File its procedure for obtaining approval of care pursuant to this section for approval by the Commissioner; and

(b) Respond to any request for approval by the insured or member pursuant to this section within 20 days after it receives the request.

2. The procedure for prior authorization may not discriminate among persons licensed to provide the covered care.

Sec. 14. Chapter 689A of NRS is hereby amended by adding thereto the provisions set forth as sections 15 to 19, inclusive, of this act.

Sec. 15. ***1. An insurer shall offer or issue a policy of health insurance to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:***

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. An insurer that offers or issues a policy of health insurance shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance

based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. An insurer that offers or issues a policy of health insurance shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 16. *1. An insurer that offers or issues a policy of health insurance which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring an insurer to make coverage available for a dependent of an adult child of an insured.

Sec. 16.5. *1. Except as otherwise provided in subsection 7, an insurer that offers or issues a policy of health insurance shall include in the policy coverage for:*

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 10;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same policy of health insurance;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.

4. Except as otherwise provided in subsections 8, 9 and 11, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit included in the policy pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

6. Except as otherwise provided in subsection 7, a policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

7. An insurer that offers or issues a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

8. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

9. For each of the 18 methods of contraception listed in subsection 10 that have been approved by the Food and Drug Administration, a policy of health insurance must include at least one drug or device for contraception within each method for

which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

10. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Ulipristal acetate for emergency contraception.

11. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

12. An insurer shall not use medical management techniques to require an insured to use a method of contraception other than the method prescribed or ordered by a provider of health care.

13. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the insurer to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

14. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or

prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 17. *1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:*

(a) Counseling and support for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration, which must

include at least one such visit per year beginning at 14 years of age;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to

determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 18. *1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between the ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between the ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny,

reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(e) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(f) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

(g) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 19. *1. An insurer that offers or issues a policy of health insurance shall include in the policy coverage for:*

(a) Screening for depression;

(b) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and

Prevention of the United States Department of Health and Human Services or its successor organization;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age; and

(d) Assessments relating to height, weight, body mass index and medical history for persons less than 18 years of age.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 20. NRS 689A.0405 is hereby amended to read as follows:

689A.0405 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for:

(a) ~~[An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40; and~~

~~(c) An annual]~~ ***A*** mammogram ***every 2 years, or annually if ordered by a provider of health care,*** for women 40 years of age or older ~~[.]~~ ***;***

(b) Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

(c) Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

2. ~~[A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. ***Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 20.3. NRS 689A.0415 is hereby amended to read as follows:

689A.0415 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of health insurance which provides coverage for prescription drugs or devices shall include in the policy coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any~~] ***any*** type of hormone replacement therapy ~~[,~~ ~~➥~~] which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a policy of health insurance that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for ~~[a contraceptive or]~~ hormone replacement therapy than is required for other prescription drugs covered by the policy;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require an insurer to provide coverage for fertility drugs.

(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by ~~[paragraphs (a) and (b) of]~~ subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the policy.

5. ~~[An insurer which offers or issues a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective~~

~~insured, written notice of the coverage that the insurer refuses to provide pursuant to this subsection.~~

~~6.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 20.6. NRS 689A.0417 is hereby amended to read as follows:

689A.0417 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. An insurer that offers or issues a policy of health insurance that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy than is required for other outpatient care covered by the policy;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the policy.

5. ~~[An insurer which offers or issues such a policy of health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.~~

~~6.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 21. NRS 689A.0425 is hereby amended to read as follows:

689A.0425 1. Except as otherwise provided in this subsection, an individual health benefit plan issued pursuant to this chapter ~~[that includes coverage for maternity care and pediatric care for newborn infants]~~ may not restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the plan to:

(a) Less than 48 hours after a normal vaginal delivery; and

(b) Less than 96 hours after a cesarean section.

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the individual health benefit plan may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any individual health benefit plan in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

2. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

(b) Stay in a hospital for a fixed period following the birth of her child.

3. An individual health benefit plan ~~[that offers coverage for maternity care and pediatric care of newborn infants]~~ may not:

(a) Deny a mother or her newborn infant coverage or continued coverage under the terms of the plan or coverage if the sole purpose of the denial of coverage or continued coverage is to avoid the requirements of this section;

(b) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protection available pursuant to this section;

(c) Penalize, or otherwise reduce or limit, the reimbursement of an attending provider of health care because the attending provider of health care provided care to a mother or newborn infant in accordance with the provisions of this section;

(d) Provide incentives of any kind to an attending physician to induce the attending physician to provide care to a mother or newborn infant in a manner that is inconsistent with the provisions of this section; or

(e) Except as otherwise provided in subsection 4, restrict benefits for any portion of a hospital stay required pursuant to the provisions of this section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

4. Nothing in this section:

(a) Prohibits an individual health benefit plan from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for hospital stays in connection with childbirth for a mother or newborn child covered by the plan, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

(b) Prohibits an arrangement for payment between an individual health benefit plan and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents an individual health benefit plan from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

5. A policy of health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 22. NRS 689A.044 is hereby amended to read as follows:

689A.044 1. A policy of health insurance must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including,

without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A policy of health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. ***Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of health insurance shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a policy of health insurance or cancel a policy of health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of this section, "human~~

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which

is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 23. NRS 689A.330 is hereby amended to read as follows:

689A.330 If any policy is issued by a domestic insurer for delivery to a person residing in another state, and if the insurance commissioner or corresponding public officer of that other state has informed the Commissioner that the policy is not subject to approval or disapproval by that officer, the Commissioner may by ruling require that the policy meet the standards set forth in NRS 689A.030 to 689A.320, inclusive ~~.~~ ***, and sections 15 to 19, inclusive, of this act.***

Sec. 24. Chapter 689B of NRS is hereby amended by adding thereto the provisions set forth as sections 25 to 28, inclusive, of this act.

Sec. 25. ***1. An insurer that offers or issues a policy of group health insurance which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.***

2. Nothing in this section shall be construed as requiring an insurer to make coverage available for a dependent of an adult child of an insured.

Sec. 25.5. ***1. Except as otherwise provided in subsection 7, an insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 11;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same policy of group health insurance;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.

4. Except as otherwise provided in subsections 9, 10 and 12, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit included in the policy pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

6. Except as otherwise provided in subsection 7, a policy subject to the provisions of this chapter that is delivered, issued for

delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

7. An insurer that offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

8. If an insurer refuses, pursuant to subsection 7, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

9. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

10. For each of the 18 methods of contraception listed in subsection 11 that have been approved by the Food and Drug Administration, a policy of group health insurance must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

11. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Ulipristal acetate for emergency contraception.

12. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

13. An insurer shall not use medical management techniques to require an insured to use a different method of contraception other than the method prescribed or ordered by a provider of health care.

14. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the insurer to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

15. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 26. *1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:*

(a) Counseling and support for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or

other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of group health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 27. *1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between the ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of group health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(e) "Network plan" means a policy of health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(f) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

(g) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 28. *1. An insurer that offers or issues a policy of group health insurance shall include in the policy coverage for:*

(a) Screening for depression;

(b) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age; and

(d) Assessments relating to height, weight, body mass index and medical history for persons less than 18 years of age.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of group health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 29. NRS 689B.0313 is hereby amended to read as follows:

689B.0313 1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for ~~[~~administering~~]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. ***Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of group health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy ***of group health insurance*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[~~July 1, 2007,~~]~~ ***January 1, 2018,*** has the legal

effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of this section, "human]~~

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 30. NRS 689B.0374 is hereby amended to read as follows:

689B.0374 1. A policy of group health insurance must provide coverage for benefits payable for expenses incurred for:

(a) ~~[An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40; and~~

~~(c) An annual]~~ ***A*** mammogram ***every 2 years, or annually if ordered by a provider of health care,*** for women 40 years of age or older ~~[.]~~ ***;***

(b) Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

(c) Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

2. ~~[A policy of group health insurance must not require an insured to obtain prior authorization for any service provided~~

~~pursuant to subsection 1.~~] ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. ***Except as otherwise provided in subsection 5, an insurer that offers or issues a policy of group health insurance shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the policy of group health insurance pursuant to subsection 1;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use a benefit provided in the policy of group health insurance pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A policy ***of group health insurance*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a policy of group health insurance offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 30.3. NRS 689B.0376 is hereby amended to read as follows:

689B.0376 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of group health insurance which provides coverage for prescription drugs or devices shall include in the policy coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[,~~

~~"]~~ which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a policy of group health insurance that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for ~~[a contraceptive or]~~ hormone replacement therapy than is required for other prescription drugs covered by the policy;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any

provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require an insurer to provide coverage for fertility drugs.

(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by ~~[paragraphs (a) and (b) of]~~ subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the policy.

5. ~~[An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 30.6. NRS 689B.0377 is hereby amended to read as follows:

689B.0377 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a policy of group health insurance which provides coverage for outpatient care shall include in the policy coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. An insurer that offers or issues a policy of group health insurance that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy than is required for other outpatient care covered by the policy;

(b) Refuse to issue a policy of group health insurance or cancel a policy of group health insurance solely because the person applying for or covered by the policy uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** policy subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the policy.

~~5. [An insurer which offers or issues a policy of group health insurance and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a policy of group health insurance and before the renewal of such a policy, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 31. NRS 689B.500 is hereby amended to read as follows:

689B.500 ~~[A carrier that issues a group health plan or coverage under blanket accident and health insurance or group health~~

~~insurance shall not deny, exclude or limit a benefit for a preexisting condition.]~~

1. An insurer shall offer or issue a policy of group health insurance to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. An insurer that offers or issues a policy of group health insurance shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. An insurer that offers or issues a policy of group health insurance shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 32. NRS 689B.520 is hereby amended to read as follows:

689B.520 1. Except as otherwise provided in this subsection, a group health plan or coverage offered under group health insurance issued pursuant to this chapter ~~[that includes coverage for maternity care and pediatric care for newborn infants]~~ may not restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the plan or coverage to:

(a) Less than 48 hours after a normal vaginal delivery; and

(b) Less than 96 hours after a cesarean section.

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the group health plan or health insurance coverage may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any group health plan

or health insurance coverage in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

2. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

(b) Stay in a hospital for a fixed period following the birth of her child.

3. A group health plan or coverage under group health insurance ~~[that offers coverage for maternity care and pediatric care of newborn infants]~~ may not:

(a) Deny a mother or her newborn infant coverage or continued coverage under the terms of the plan or coverage if the sole purpose of the denial of coverage or continued coverage is to avoid the requirements of this section;

(b) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protection available pursuant to this section;

(c) Penalize, or otherwise reduce or limit, the reimbursement of an attending provider of health care because the attending provider of health care provided care to a mother or newborn infant in accordance with the provisions of this section;

(d) Provide incentives of any kind to an attending physician to induce the attending physician to provide care to a mother or newborn infant in a manner that is inconsistent with the provisions of this section; or

(e) Except as otherwise provided in subsection 4, restrict benefits for any portion of a hospital stay required pursuant to the provisions of this section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

4. Nothing in this section:

(a) Prohibits a group health plan or carrier from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for hospital stays in connection with childbirth for a mother or newborn child covered by the plan, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

(b) Prohibits an arrangement for payment between a group health plan or carrier and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents a group health plan or carrier from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

5. A policy of group health insurance subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with this section is void.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 33. Chapter 689C of NRS is hereby amended by adding thereto the provisions set forth as sections 34 to 39, inclusive, of this act.

Sec. 34. ***1. A carrier that offers or issues a health benefit plan which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.***

2. Nothing in this section shall be construed as requiring a carrier to make coverage available for a dependent of an adult child of an insured.

Sec. 34.5. ***1. Except as otherwise provided in subsection 7, a carrier that offers or issues a health benefit plan shall include in the plan coverage for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 10;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same health benefit plan;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the carrier.

4. Except as otherwise provided in subsections 8, 9 and 11, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit included in the plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

6. Except as otherwise provided in subsection 7, a health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

7. A carrier that offers or issues a health benefit plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the carrier objects on religious grounds. Such a carrier shall, before the issuance of a health benefit plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the carrier refuses to provide pursuant to this subsection.

8. A carrier may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

9. For each of the 18 methods of contraception listed in subsection 10 that have been approved by the Food and Drug Administration, a health benefit plan must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the carrier may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

10. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Ulipristal acetate for emergency contraception.

11. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

12. A carrier shall not use medical management techniques to require an insured to use a different method of contraception other than the method prescribed or ordered by a provider of health care.

13. A carrier must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management

technique used by the carrier to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

14. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 35. *1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:*

(a) Counseling and support for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health benefit plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage

required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 36. *1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between the ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health benefit plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(e) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(f) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

(g) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 37. *1. A carrier that offers or issues a health benefit plan shall include in the plan coverage for:*

(a) Screening for depression;

(b) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age; and

(d) Assessments relating to height, weight, body mass index and medical history for persons less than 18 years of age.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health benefit plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques,

including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 38. *1. A health benefit plan must provide coverage for benefits payable for expenses incurred for:*

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health benefit plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A health benefit plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 39. *1. A health benefit plan must provide coverage for benefits payable for expenses incurred for:*

(a) A mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older;

(b) Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

(c) Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

2. A carrier must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the carrier.

3. Except as otherwise provided in subsection 5, a carrier that offers or issues a health benefit plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health benefit plan pursuant to subsection 1;

(b) Refuse to issue a health benefit plan or cancel a health benefit plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health benefit plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A health benefit plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a carrier may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health benefit plan offered by a carrier under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the carrier. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 40. NRS 689C.159 is hereby amended to read as follows:

689C.159 The provisions of NRS 689C.156 ~~[and 689C.190]~~ do not apply to health benefit plans offered by a carrier if the carrier makes the health benefit plan available in the small employer market only through a bona fide association.

Sec. 41. NRS 689C.190 is hereby amended to read as follows:

689C.190 ~~[A carrier serving small employers that issues a health benefit plan shall not deny, exclude or limit a benefit for a preexisting condition.]~~

1. A carrier shall offer or issue a health benefit plan to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A carrier that offers or issues a health benefit plan shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. A carrier that offers or issues a health benefit plan shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 42. NRS 689C.193 is hereby amended to read as follows:

689C.193 1. A carrier shall not place any restriction on a small employer or an eligible employee or a dependent of the eligible employee as a condition of being a participant in or a beneficiary of a health benefit plan that is inconsistent with NRS 689C.015 to 689C.355, inclusive ~~.~~ ***, and sections 34 to 39, inclusive, of this act.***

2. A carrier that offers health insurance coverage to small employers pursuant to this chapter shall not establish rules of eligibility, including, but not limited to, rules which define applicable waiting periods, for the initial or continued enrollment under a health benefit plan offered by the carrier that are based on the following factors relating to the eligible employee or a dependent of the eligible employee:

(a) Health status.

(b) Medical condition, including physical and mental illnesses, or both.

(c) Claims experience.

(d) Receipt of health care.

(e) Medical history.

(f) Genetic information.

(g) Evidence of insurability, including conditions which arise out of acts of domestic violence.

(h) Disability.

3. Except as otherwise provided in NRS 689C.190, the provisions of subsection 1 do not require a carrier to provide particular benefits other than those that would otherwise be provided under the terms of the health benefit plan or coverage.

4. As a condition of enrollment or continued enrollment under a health benefit plan, a carrier shall not require any person to pay a premium or contribution that is greater than the premium or contribution for a similarly situated person covered by similar coverage on the basis of any factor described in subsection 2 in relation to the person or a dependent of the person.

5. Nothing in this section:

(a) Restricts the amount that a small employer may be charged for coverage by a carrier;

(b) Prevents a carrier from establishing premium discounts or rebates or from modifying otherwise applicable copayments or deductibles in return for adherence by the insured person to programs of health promotion and disease prevention; or

(c) Precludes a carrier from establishing rules relating to employer contribution or group participation when offering health insurance coverage to small employers in this State.

6. As used in this section:

(a) "Contribution" means the minimum employer contribution toward the premium for enrollment of participants and beneficiaries in a health benefit plan.

(b) "Group participation" means the minimum number of participants or beneficiaries that must be enrolled in a health benefit plan in relation to a specified percentage or number of eligible persons or employees of the employer.

Sec. 43. NRS 689C.194 is hereby amended to read as follows:

689C.194 1. Except as otherwise provided in this subsection, a health benefit plan issued pursuant to this chapter ~~[that includes coverage for maternity care and pediatric care for newborn infants]~~ may not restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the plan to:

(a) Less than 48 hours after a normal vaginal delivery; and

(b) Less than 96 hours after a cesarean section.

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the health benefit plan may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any health benefit plan in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

2. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

(b) Stay in a hospital for a fixed period following the birth of her child.

3. A health benefit plan ~~[that offers coverage for maternity care and pediatric care of newborn infants]~~ may not:

(a) Deny a mother or her newborn infant coverage or continued coverage under the terms of the plan if the sole purpose of the denial of coverage or continued coverage is to avoid the requirements of this section;

(b) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protection available pursuant to this section;

(c) Penalize, or otherwise reduce or limit, the reimbursement of an attending provider of health care because the attending provider of health care provided care to a mother or newborn infant in accordance with the provisions of this section;

(d) Provide incentives of any kind to an attending physician to induce the attending physician to provide care to a mother or

newborn infant in a manner that is inconsistent with the provisions of this section; or

(e) Except as otherwise provided in subsection 4, restrict benefits for any portion of a hospital stay required pursuant to the provisions of this section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

4. Nothing in this section:

(a) Prohibits a health benefit plan or carrier from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for hospital stays in connection with childbirth for a mother or newborn child covered by the plan, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

(b) Prohibits an arrangement for payment between a health benefit plan or carrier and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents a health benefit plan or carrier from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

5. A health benefit plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 44. NRS 689C.270 is hereby amended to read as follows:

689C.270 1. The Commissioner shall adopt regulations which require a carrier to file with the Commissioner, for approval by the Commissioner, a disclosure offered by the carrier to a small employer. The disclosure must include:

(a) Any significant exception, reduction or limitation that applies to the policy;

(b) Any restrictions on payments for emergency care, including, without limitation, related definitions of an emergency and medical necessity;

(c) The provision of the health benefit plan concerning the carrier's right to change premium rates and the characteristics, other than claim experience, that affect changes in premium rates;

(d) The provisions relating to renewability of policies and contracts; ***and***

(e) ~~[The provisions relating to any preexisting condition; and~~

~~(f)]~~ Any other information that the Commissioner finds necessary to provide for full and fair disclosure of the provisions of a policy or contract of insurance issued pursuant to this chapter.

2. The disclosure must be written in language which is easily understood and must include a statement that the disclosure is a summary of the policy only, and that the policy itself should be read to determine the governing contractual provisions.

3. The Commissioner shall not approve any proposed disclosure submitted to the Commissioner pursuant to this section which does not comply with the requirements of this section and the applicable regulations.

4. The carrier shall make available to a small employer or a producer acting on behalf of a small employer, upon request, a copy of the disclosure approved by the Commissioner pursuant to this section for policies of health insurance for which that employer may be eligible.

Sec. 45. NRS 689C.425 is hereby amended to read as follows:

689C.425 A voluntary purchasing group and any contract issued to such a group pursuant to NRS 689C.360 to 689C.600, inclusive, are subject to the provisions of NRS 689C.015 to 689C.355, inclusive, ***and sections 34 to 39, inclusive, of this act,*** to the extent applicable and not in conflict with the express provisions of NRS 687B.408 and 689C.360 to 689C.600, inclusive.

Sec. 46. NRS 689C.440 is hereby amended to read as follows:

689C.440 1. The Commissioner shall adopt regulations which require a carrier to file with the Commissioner, for approval by the Commissioner, a disclosure offered by the carrier to a voluntary purchasing group. The disclosure must include:

(a) Any significant exception, prior authorization, reduction or limitation that applies to a contract;

(b) Any restrictions on payments for emergency care, including, without limitation, related definitions of an emergency and medical necessity;

(c) Any provision of a contract concerning the carrier's right to change premium rates and the characteristics, other than claim experience, that affect changes in premium rates;

(d) The provisions relating to renewability of contracts; ***and***

(e) ~~[The provisions relating to any preexisting condition; and~~

~~(f)]~~ Any other information that the Commissioner finds necessary to provide for full and fair disclosure of the provisions of a contract.

2. The disclosure must be written in a language which is easily understood and must include a statement that the disclosure is a

summary of the contract only, and that the contract itself should be read to determine the governing contractual provisions.

3. The Commissioner shall not approve any proposed disclosure submitted to the Commissioner pursuant to this section which does not comply with the requirements of this section and the applicable regulations.

Sec. 47. Chapter 695A of NRS is hereby amended by adding thereto the provisions set forth as sections 48 to 55, inclusive, of this act.

Sec. 48. ***1. A society shall offer or issue a benefit contract to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:***

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A society that offers or issues a benefit contract shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. A society that offers or issues a benefit contract shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 49. ***1. A society that offers or issues a benefit contract which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.***

2. Nothing in this section shall be construed as requiring a society to make coverage available for a dependent of an adult child of an insured.

Sec. 49.5. ***1. Except as otherwise provided in subsection 7, a society that offers or issues a benefit contract shall include in the plan coverage for:***

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 10;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same benefit contract;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the society.

4. Except as otherwise provided in subsections 8, 9 and 11, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit included in the plan pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

6. Except as otherwise provided in subsection 7, a benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

7. A society that offers or issues a benefit contract and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the society objects on religious grounds. Such a society shall, before the issuance of a benefit contract and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the society refuses to provide pursuant to this subsection.

8. A society may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

9. For each of the 18 methods of contraception listed in subsection 10 that have been approved by the Food and Drug Administration, a benefit contract must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the society may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

10. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Ulipristal acetate for emergency contraception.

11. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

12. A society shall not use medical management techniques to require an insured to use a different method of contraception other than the method prescribed or ordered by a provider of health care.

13. A society must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the society to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

14. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 50. *1. A society that offers or issues a benefit contract shall include in the contract coverage for:*

(a) Counseling and support for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or

other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use a benefit provided in the benefit contract pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 51. *1. A society that offers or issues a benefit contract shall include in the contract coverage for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between the ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between the ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use a benefit provided in the benefit contract pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(e) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the society. The term does not include an arrangement for the financing of premiums.

(f) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

(g) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 52. *1. A society that offers or issues a benefit contract shall include in the contract coverage for:*

(a) Screening for depression;

(b) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age; and

(d) Assessments relating to height, weight, body mass index and medical history for persons less than 18 years of age.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the

contract uses or may use a benefit provided in the benefit contract pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 53. *1. Except as otherwise provided in this subsection, a benefit contract issued pursuant to this chapter may not restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the contract to:*

(a) Less than 48 hours after a normal vaginal delivery; and

(b) Less than 96 hours after a cesarean section.

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the benefit contract may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any benefit contract in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

2. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

(b) Stay in a hospital for a fixed period following the birth of her child.

3. A benefit contract may not:

(a) Deny a mother or her newborn infant coverage or continued coverage under the terms of the contract or coverage if the sole purpose of the denial of coverage or continued coverage is to avoid the requirements of this section;

(b) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protection available pursuant to this section;

(c) Penalize, or otherwise reduce or limit, the reimbursement of an attending provider of health care because the attending provider of health care provided care to a mother or newborn infant in accordance with the provisions of this section;

(d) Provide incentives of any kind to an attending physician to induce the attending physician to provide care to a mother or newborn infant in a manner that is inconsistent with the provisions of this section; or

(e) Except as otherwise provided in subsection 4, restrict benefits for any portion of a hospital stay required pursuant to the provisions of this section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

4. Nothing in this section:

(a) Prohibits a benefit contract from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for hospital stays in connection with childbirth for a mother or newborn child covered by the contract, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

(b) Prohibits an arrangement for payment between a benefit contract or society and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents a benefit contract or society from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

5. A benefit contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 54. *1. A benefit contract must provide coverage for benefits payable for expenses incurred for:*

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use a benefit provided in the benefit contract pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the society. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 55. *1. A benefit contract must provide coverage for benefits payable for expenses incurred for:*

(a) A mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older;

(b) Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

(c) Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

2. A society must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the society.

3. Except as otherwise provided in subsection 5, a society that offers or issues a benefit contract shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the benefit contract pursuant to subsection 1;

(b) Refuse to issue a benefit contract or cancel a benefit contract solely because the person applying for or covered by the contract uses or may use a benefit provided in the benefit contract pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A benefit contract subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a society may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a benefit contract offered by a society under which the financing and delivery of medical care, including items and services paid for as medical care, are

provided, in whole or in part, through a defined set of providers of health care under contract with the society. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 56. Chapter 695B of NRS is hereby amended by adding thereto the provisions set forth as sections 57 to 62, inclusive, of this act.

Sec. 57. *1. An insurer shall offer or issue a contract for hospital or medical service to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:*

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. An insurer that offers or issues a contract for hospital or medical service shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. An insurer that offers or issues a contract for hospital or medical service shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 58. *1. An insurer that offers or issues a contract for hospital or medical service which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring a hospital or medical service corporation to make coverage available for a dependent of an adult child of an insured.

Sec. 58.5. *1. Except as otherwise provided in subsection 7, an insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:*

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 11;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same contract for hospital or medical service;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the insurer.

4. Except as otherwise provided in subsections 9, 10 and 12, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit included in the contract pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny,

reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

6. Except as otherwise provided in subsection 7, a contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

7. An insurer that offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the prospective insured written notice of the coverage that the insurer refuses to provide pursuant to this subsection.

8. If an insurer refuses, pursuant to subsection 7, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

9. An insurer may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

10. For each of the 18 methods of contraception listed in subsection 11 that have been approved by the Food and Drug Administration, a contract for hospital or medical service must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the insurer may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

11. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Ulipristal acetate for emergency contraception.

12. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

13. An insurer shall not use medical management techniques to require an insured to use a different method of contraception other than the method prescribed or ordered by a provider of health care.

14. An insurer must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the insurer to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

15. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 59. *1. An insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:*

(a) Counseling and support for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use a benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the

use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 60. *1. An insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between the ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between the ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use a benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(e) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(f) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

(g) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 61. *1. An insurer that offers or issues a contract for hospital or medical service shall include in the contract coverage for:*

(a) Screening for depression;

(b) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age; and

(d) Assessments relating to height, weight, body mass index and medical history for persons less than 18 years of age.

2. An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.

3. Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use a benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 62. *1. Except as otherwise provided in this subsection, a contract for hospital or medical service issued pursuant to this chapter may not restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the contract to:*

(a) Less than 48 hours after a normal vaginal delivery; and

(b) Less than 96 hours after a cesarean section.

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the contract for hospital or medical service may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any contract for hospital or medical service in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

2. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

(b) Stay in a hospital for a fixed period following the birth of her child.

3. A contract for hospital or medical service may not:

(a) Deny a mother or her newborn infant coverage or continued coverage under the terms of the contract or coverage if the sole purpose of the denial of coverage or continued coverage is to avoid the requirements of this section;

(b) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protection available pursuant to this section;

(c) Penalize, or otherwise reduce or limit, the reimbursement of an attending provider of health care because the attending provider of health care provided care to a mother or newborn infant in accordance with the provisions of this section;

(d) Provide incentives of any kind to an attending physician to induce the attending physician to provide care to a mother or newborn infant in a manner that is inconsistent with the provisions of this section; or

(e) Except as otherwise provided in subsection 4, restrict benefits for any portion of a hospital stay required pursuant to the provisions of this section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

4. Nothing in this section:

(a) Prohibits a contract for hospital or medical service from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for hospital stays in connection with childbirth for a mother or newborn child covered by the contract, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

(b) Prohibits an arrangement for payment between an insurer and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents an insurer from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

5. A contract for hospital or medical service subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 63. NRS 695B.1912 is hereby amended to read as follows:

695B.1912 1. A ~~[policy of health insurance]~~ ***contract for hospital or medical service*** issued by a hospital or medical service corporation must provide coverage for benefits payable for expenses incurred for:

(a) ~~[An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40; and~~

~~(c) An annual~~ ***A*** mammogram ***every 2 years, or annually if ordered by a provider of health care,*** for women 40 years of age or older ~~.~~ ***;***

(b) Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

(c) Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

2. ~~A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. ***Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use a benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A ~~policy~~ ***contract for hospital or medical service*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~October 1, 1989,~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the ~~policy~~ ***contract*** or the renewal which is in conflict with ~~subsection 1~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 63.3. NRS 695B.1916 is hereby amended to read as follows:

695B.1916 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a contract for hospital or medical service which provides coverage for prescription drugs or devices shall include in the contract coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any]~~ ***any*** type of hormone replacement therapy ~~[,~~ ~~➥]~~ which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. An insurer that offers or issues a contract for hospital or medical service that provides coverage for prescription drugs shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for a prescription for ~~[a contraceptive or]~~ hormone replacement therapy than is required for other prescription drugs covered by the contract;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require an insurer to provide coverage for fertility drugs.

(b) Prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by ~~[paragraphs (a) and (b) of]~~ subsection 1 that is the same as the insured is required to pay for other prescription drugs covered by the contract.

~~5. [An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 63.6. NRS 695B.1918 is hereby amended to read as follows:

695B.1918 1. ~~[Except as otherwise provided in subsection 5, an]~~ ***An*** insurer that offers or issues a contract for hospital or medical service which provides coverage for outpatient care shall include in the contract coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. An insurer that offers or issues a contract for hospital or medical service that provides coverage for outpatient care shall not:

(a) Require an insured to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy than is required for other outpatient care covered by the contract;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the person applying for or covered by the contract uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an insured.

3. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** contract subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the contract or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit an insurer from requiring an insured to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the insured is required to pay for other outpatient care covered by the contract.

5. ~~[An insurer which offers or issues a contract for hospital or medical service and which is affiliated with a religious organization is not required to provide the coverage for health care service related~~

~~to contraceptives required by this section if the insurer objects on religious grounds. Such an insurer shall, before the issuance of a contract for hospital or medical service and before the renewal of such a contract, provide to the group policyholder or prospective insured, as applicable, written notice of the coverage that the insurer refuses to provide pursuant to this subsection. The insurer shall provide notice to each insured, at the time the insured receives his or her certificate of coverage or evidence of coverage, that the insurer refused to provide coverage pursuant to this subsection.~~

~~6. If an insurer refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.~~] As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 64. NRS 695B.1925 is hereby amended to read as follows:

695B.1925 1. A ~~[policy of health insurance]~~ ***contract for hospital or medical service*** issued by a hospital or medical service corporation must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine ~~[to women and girls]~~ at such ages as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A policy of health insurance issued by a hospital or medical service corporation must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***An insurer must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the insurer.***

3. ***Except as otherwise provided in subsection 5, an insurer that offers or issues a contract for hospital or medical service shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(b) Refuse to issue a contract for hospital or medical service or cancel a contract for hospital or medical service solely because the

person applying for or covered by the contract uses or may use a benefit provided in the contract for hospital or medical service pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. A ~~[policy]~~ ***contract for hospital or medical service*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the policy or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of this section, "human~~]

5. Except as otherwise provided in this section and federal law, an insurer may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a contract for hospital or medical service offered by an insurer under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the insurer. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 65. NRS 695B.193 is hereby amended to read as follows:

695B.193 1. All individual and group service or indemnity-type contracts issued by a nonprofit corporation which provide coverage for a family member of the subscriber must as to such coverage provide that the health benefits applicable for children are payable with respect to:

(a) A newly born child of the subscriber from the moment of birth;

(b) An adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption; and

(c) A child placed with the subscriber for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of such a child ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement.

➥ The contracts must provide the coverage specified in subsection 3, and must not exclude premature births.

2. The contract may require that notification of:

(a) The birth of a newly born child;

(b) The effective date of adoption of a child; or

(c) The date of placement of a child for adoption,

➥ and payments of the required fees, if any, must be furnished to the nonprofit service corporation within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

3. The coverage for newly born and adopted children and children placed for adoption consists of coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

4. ~~[A corporation shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to that contract. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689C.190.~~

~~5.]~~ For covered services provided to the child, the corporation shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization

has agreements, contracts or arrangements for those covered services.

Sec. 66. NRS 695B.2555 is hereby amended to read as follows:

695B.2555 A ~~[converted contract must not exclude a preexisting condition not excluded by the group contract, but a]~~ converted contract may provide that any hospital, surgical or medical benefits payable under it may be reduced by the amount of any benefits payable under the group contract after his or her termination. A converted contract may provide that during the first contract year the benefits payable under it, together with the benefits payable under the group contract, must not exceed those that would have been payable if the subscriber's coverage under the group contract had remained in effect.

Sec. 67. Chapter 695C of NRS is hereby amended by adding thereto the provisions set forth as sections 68 to 73, inclusive, of this act.

Sec. 68. ***1. A health maintenance organization shall offer or issue a health care plan to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:***

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A health maintenance organization that offers or issues a health care plan shall not:

(a) Deny, limit or exclude a benefit based on the health status of an enrollee; or

(b) Require an enrollee, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated enrollee or the covered dependent of such an enrollee who does not have such a health status.

3. A health maintenance organization that offers or issues a health care plan shall not adjust a premium, deductible, copay or coinsurance for any enrollee on the basis of genetic information relating to the enrollee or the covered dependent of the enrollee.

Sec. 69. ***1. A health maintenance organization that offers or issues a health care plan which provides coverage for***

dependent children shall continue to make such coverage available for an adult child of an enrollee until such child reaches 26 years of age.

2. Nothing in this section shall be construed as requiring a health maintenance organization to make coverage available for a dependent of an adult child of an enrollee.

Sec. 69.5. *1. Except as otherwise provided in subsection 7, a health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 11; and

(4) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 11;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the enrollee was covered by the same health care plan;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the health maintenance organization.

4. Except as otherwise provided in subsections 9, 10 and 12, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit included in the plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

5. Coverage pursuant to this section for the covered dependent of an enrollee must be the same as for the enrollee.

6. Except as otherwise provided in subsection 7, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

7. A health maintenance organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the health maintenance organization objects on religious grounds. Such a health maintenance organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective enrollee written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection.

8. If a health maintenance organization refuses, pursuant to subsection 7, to provide the coverage required by subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.

9. A health maintenance organization may require an enrollee to pay a higher deductible, copayment or coinsurance for a drug for contraception if the enrollee refuses to accept a therapeutic equivalent of the drug.

10. For each of the 18 methods of contraception listed in subsection 11 that have been approved by the Food and Drug Administration, a health care plan must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the

enrollee, but the health maintenance organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

11. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Ulipristal acetate for emergency contraception.

12. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

13. A health maintenance organization shall not use medical management techniques to require an enrollee to use a different method of contraception other than the method prescribed or ordered by a provider of health care.

14. A health maintenance organization must provide an accessible, transparent and expedited process which is not unduly burdensome by which an enrollee, or the authorized representative of the enrollee, may request an exception relating to any medical management technique used by the health maintenance organization to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

15. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or

prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 70. *1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Counseling and support for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of

coverage or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 71. *1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between the ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between the ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(e) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(f) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

(g) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 72. *1. A health maintenance organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Screening for depression;

(b) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age; and

(d) Assessments relating to height, weight, body mass index and medical history for persons less than 18 years of age.

2. A health maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.

3. Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 73. *1. Except as otherwise provided in this subsection, an evidence of coverage issued pursuant to this chapter may not restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the health care plan to:*

(a) Less than 48 hours after a normal vaginal delivery; and

(b) Less than 96 hours after a cesarean section.

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the health care plan may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any health care plan in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

2. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

(b) Stay in a hospital for a fixed period following the birth of her child.

3. A health care plan may not:

(a) Deny a mother or her newborn infant coverage or continued coverage under the terms of the plan or coverage if the sole purpose of the denial of coverage or continued coverage is to avoid the requirements of this section;

(b) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protection available pursuant to this section;

(c) Penalize, or otherwise reduce or limit, the reimbursement of an attending provider of health care because the attending provider of health care provided care to a mother or newborn infant in accordance with the provisions of this section;

(d) Provide incentives of any kind to an attending physician to induce the attending physician to provide care to a mother or newborn infant in a manner that is inconsistent with the provisions of this section; or

(e) Except as otherwise provided in subsection 4, restrict benefits for any portion of a hospital stay required pursuant to the provisions of this section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

4. Nothing in this section:

(a) Prohibits a health care plan from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for hospital stays in connection with childbirth for a mother or newborn child covered by the plan, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

(b) Prohibits an arrangement for payment between a health maintenance organization and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents a health maintenance organization from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

5. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of

coverage or the renewal which is in conflict with this section is void.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 74. NRS 695C.050 is hereby amended to read as follows:

695C.050 1. Except as otherwise provided in this chapter or in specific provisions of this title, the provisions of this title are not applicable to any health maintenance organization granted a certificate of authority under this chapter. This provision does not apply to an insurer licensed and regulated pursuant to this title except with respect to its activities as a health maintenance organization authorized and regulated pursuant to this chapter.

2. Solicitation of enrollees by a health maintenance organization granted a certificate of authority, or its representatives, must not be construed to violate any provision of law relating to solicitation or advertising by practitioners of a healing art.

3. Any health maintenance organization authorized under this chapter shall not be deemed to be practicing medicine and is exempt from the provisions of chapter 630 of NRS.

4. The provisions of NRS 695C.110, 695C.125, 695C.1691, 695C.1693, 695C.170, 695C.1703, 695C.1705, 695C.1709 to 695C.173, inclusive, 695C.1733, 695C.17335, 695C.1734, ~~[695C.1735 to]~~ ***695C.1751,*** 695C.1755, ~~[inclusive,]~~ 695C.176 to 695C.200, inclusive, and 695C.265 do not apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid or insurance pursuant to the Children's Health Insurance Program pursuant to a contract with the Division of Health Care Financing and Policy of the Department of Health and Human Services. This subsection does not exempt a health maintenance organization from any provision of this chapter for services provided pursuant to any other contract.

5. The provisions of NRS 695C.1694, 695C.1695, 695C.1708, 695C.1731, 695C.17345 ~~[and]~~ ***, 695C.1735, 695C.1745 and*** 695C.1757 ***and sections 68 to 73, inclusive, of this act*** apply to a health maintenance organization that provides health care services through managed care to recipients of Medicaid under the State Plan for Medicaid.

Sec. 74.3. NRS 695C.1694 is hereby amended to read as follows:

695C.1694 1. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** health maintenance organization which offers or issues a health care plan that provides coverage for prescription drugs or devices shall include in the plan coverage for ~~[:~~

~~(a) Any type of drug or device for contraception; and~~

~~(b) Any~~] ***any*** type of hormone replacement therapy ~~[,~~ ~~➥~~] which is lawfully prescribed or ordered and which has been approved by the Food and Drug Administration.

2. A health maintenance organization that offers or issues a health care plan that provides coverage for prescription drugs shall not:

(a) Require an enrollee to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for ~~[a prescription for a contraceptive or]~~ hormone replacement therapy than is required for other prescription drugs covered by the plan;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee.

3. ~~[Except as otherwise provided in subsection 5, evidence]~~ ***Evidence*** of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. The provisions of this section do not:

(a) Require a health maintenance organization to provide coverage for fertility drugs.

(b) Prohibit a health maintenance organization from requiring an enrollee to pay a deductible, copayment or coinsurance for the coverage required by ~~[paragraphs (a) and (b) of]~~ subsection 1 that is the same as the enrollee is required to pay for other prescription drugs covered by the plan.

5. ~~[A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by paragraph (a) of subsection 1 if the health maintenance organization objects on~~

~~religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his or her evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.~~

~~6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.~~] As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 74.6. NRS 695C.1695 is hereby amended to read as follows:

695C.1695 1. ~~[Except as otherwise provided in subsection 5, a]~~ ***A*** health maintenance organization that offers or issues a health care plan which provides coverage for outpatient care shall include in the plan coverage for any health care service related to ~~[contraceptives or]~~ hormone replacement therapy.

2. A health maintenance organization that offers or issues a health care plan that provides coverage for outpatient care shall not:

(a) Require an enrollee to pay a higher deductible, copayment or coinsurance or require a longer waiting period or other condition for coverage for outpatient care related to ~~[contraceptives or]~~ hormone replacement therapy than is required for other outpatient care covered by the plan;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use in the future ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from accessing ~~[any of the services listed in subsection 1;]~~ ***hormone replacement therapy;***

(d) Penalize a provider of health care who provides ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care; or

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay ~~[any of the services listed in subsection 1]~~ ***hormone replacement therapy*** to an enrollee.

3. ~~[Except as otherwise provided in subsection 5, evidence]~~ ***Evidence*** of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after October 1, 1999, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

4. The provisions of this section do not prohibit a health maintenance organization from requiring an enrollee to pay a deductible, copayment or coinsurance for the coverage required by subsection 1 that is the same as the enrollee is required to pay for other outpatient care covered by the plan.

5. ~~[A health maintenance organization which offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage for health care service related to contraceptives required by this section if the health maintenance organization objects on religious grounds. The health maintenance organization shall, before the issuance of a health care plan and before renewal of enrollment in such a plan, provide to the group policyholder or prospective enrollee, as applicable, written notice of the coverage that the health maintenance organization refuses to provide pursuant to this subsection. The health maintenance organization shall provide notice to each enrollee, at the time the enrollee receives his or her evidence of coverage, that the health maintenance organization refused to provide coverage pursuant to this subsection.~~

~~6. If a health maintenance organization refuses, pursuant to subsection 5, to provide the coverage required by paragraph (a) of subsection 1, an employer may otherwise provide for the coverage for the employees of the employer.~~

~~7.]~~ As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 75. NRS 695C.173 is hereby amended to read as follows:

695C.173 1. All individual and group health care plans which provide coverage for a family member of the enrollee must as to such coverage provide that the health care services applicable for children are payable with respect to:

(a) A newly born child of the enrollee from the moment of birth;

(b) An adopted child from the date the adoption becomes effective, if the child was not placed in the home before adoption; and

(c) A child placed with the enrollee for the purpose of adoption from the moment of placement as certified by the public or private agency making the placement. The coverage of such a child ceases if the adoption proceedings are terminated as certified by the public or private agency making the placement.

➥ The plans must provide the coverage specified in subsection 3, and must not exclude premature births.

2. The evidence of coverage may require that notification of:

(a) The birth of a newly born child;

(b) The effective date of adoption of a child; or

(c) The date of placement of a child for adoption,

➥ and payments of the required charge, if any, must be furnished to the health maintenance organization within 31 days after the date of birth, adoption or placement for adoption in order to have the coverage continue beyond the 31-day period.

3. The coverage for newly born and adopted children and children placed for adoption consists of preventive health care services as well as coverage of injury or sickness, including the necessary care and treatment of medically diagnosed congenital defects and birth abnormalities and, within the limits of the policy, necessary transportation costs from place of birth to the nearest specialized treatment center under major medical policies, and with respect to basic policies to the extent such costs are charged by the treatment center.

4. ~~[A health maintenance organization shall not restrict the coverage of a dependent child adopted or placed for adoption solely because of a preexisting condition the child has at the time the child would otherwise become eligible for coverage pursuant to that plan. Any provision relating to an exclusion for a preexisting condition must comply with NRS 689B.500 or 689C.190, as appropriate.~~

~~5.]~~ For covered services provided to the child, the health maintenance organization shall reimburse noncontracted providers of health care to an amount equal to the average amount of payment for which the organization has agreements, contracts or arrangements for those covered services.

Sec. 76. NRS 695C.1735 is hereby amended to read as follows:

695C.1735 1. A health maintenance ***organization which offers or issues a health care*** plan must provide coverage for benefits payable for expenses incurred for:

(a) ~~[An annual cytologic screening test for women 18 years of age or older;~~

~~(b) A baseline mammogram for women between the ages of 35 and 40; and~~

~~(c) An annual]~~ ***A*** mammogram ***every 2 years, or annually if ordered by a provider of health care,*** for women 40 years of age or older ~~[.]~~ ***;***

(b) Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

(c) Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

2. A health maintenance ~~[plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.***

3. ***Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:***

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. ~~[A policy]~~ ***An evidence of coverage*** subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[October 1, 1989,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the ~~[policy]~~ ***evidence of coverage*** or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 77. NRS 695C.1745 is hereby amended to read as follows:

695C.1745 1. A health care plan of a health maintenance organization must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. A health ~~[care plan of a health maintenance organization must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***maintenance organization must ensure that the benefits required by subsection 1 are made available to an enrollee through a provider of health care who participates in the network plan of the health maintenance organization.***

3. ***Except as otherwise provided in subsection 5, a health maintenance organization that offers or issues a health care plan shall not:***

(a) Require an enrollee to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an enrollee to discourage the enrollee from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an enrollee, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an enrollee; or

(f) Impose any other restrictions or delays on the access of an enrollee to any such benefit.

4. Any evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of this section, "human~~

5. Except as otherwise provided in this section and federal law, a health maintenance organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a health care plan offered by a health maintenance organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the health maintenance organization. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 78. NRS 695C.330 is hereby amended to read as follows:

695C.330 1. The Commissioner may suspend or revoke any certificate of authority issued to a health maintenance organization pursuant to the provisions of this chapter if the Commissioner finds that any of the following conditions exist:

(a) The health maintenance organization is operating significantly in contravention of its basic organizational document, its health care plan or in a manner contrary to that described in and reasonably inferred from any other information submitted pursuant to NRS 695C.060, 695C.070 and 695C.140, unless any amendments to those submissions have been filed with and approved by the Commissioner;

(b) The health maintenance organization issues evidence of coverage or uses a schedule of charges for health care services which do not comply with the requirements of NRS 695C.1691 to 695C.200, inclusive, ***and sections 68 to 73, inclusive, of this act*** or 695C.207;

(c) The health care plan does not furnish comprehensive health care services as provided for in NRS 695C.060;

(d) The Commissioner certifies that the health maintenance organization:

(1) Does not meet the requirements of subsection 1 of NRS 695C.080; or

(2) Is unable to fulfill its obligations to furnish health care services as required under its health care plan;

(e) The health maintenance organization is no longer financially responsible and may reasonably be expected to be unable to meet its obligations to enrollees or prospective enrollees;

(f) The health maintenance organization has failed to put into effect a mechanism affording the enrollees an opportunity to participate in matters relating to the content of programs pursuant to NRS 695C.110;

(g) The health maintenance organization has failed to put into effect the system required by NRS 695C.260 for:

(1) Resolving complaints in a manner reasonably to dispose of valid complaints; and

(2) Conducting external reviews of adverse determinations that comply with the provisions of NRS 695G.241 to 695G.310, inclusive;

(h) The health maintenance organization or any person on its behalf has advertised or merchandised its services in an untrue, misrepresentative, misleading, deceptive or unfair manner;

(i) The continued operation of the health maintenance organization would be hazardous to its enrollees;

(j) The health maintenance organization fails to provide the coverage required by NRS 695C.1691; or

(k) The health maintenance organization has otherwise failed to comply substantially with the provisions of this chapter.

2. A certificate of authority must be suspended or revoked only after compliance with the requirements of NRS 695C.340.

3. If the certificate of authority of a health maintenance organization is suspended, the health maintenance organization shall not, during the period of that suspension, enroll any additional groups or new individual contracts, unless those groups or persons were contracted for before the date of suspension.

4. If the certificate of authority of a health maintenance organization is revoked, the organization shall proceed, immediately following the effective date of the order of revocation, to wind up its affairs and shall conduct no further business except as may be essential to the orderly conclusion of the affairs of the organization. It shall engage in no further advertising or solicitation of any kind. The Commissioner may, by written order, permit such further operation of the organization as the Commissioner may find to be in the best interest of enrollees to the end that enrollees are afforded the greatest practical opportunity to obtain continuing coverage for health care.

Sec. 79. Chapter 695F of NRS is hereby amended by adding thereto the provisions set forth as sections 80 and 81 of this act.

Sec. 80. ***1. A prepaid limited health service organization shall offer or issue evidence of coverage to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:***

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A prepaid limited health service organization that offers or issues evidence of coverage shall not:

(a) Deny, limit or exclude a benefit based on the health status of an enrollee; or

(b) Require an enrollee, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly

situated enrollee or the covered dependent of such an enrollee who does not have such a health status.

3. A prepaid limited health service organization that offers or issues evidence of coverage shall not adjust a premium, deductible, copay or coinsurance for any enrollee on the basis of genetic information relating to the enrollee or the covered dependent of the enrollee.

Sec. 81. *1. A prepaid limited health service organization that offers or issues evidence of coverage which provides coverage for dependent children shall continue to make such coverage available for an adult child of an enrollee until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring a prepaid limited health service organization to make coverage available for a dependent of an adult child of an enrollee.

Sec. 82. Chapter 695G of NRS is hereby amended by adding thereto the provisions set forth as sections 83 to 89, inclusive, of this act.

Sec. 83. *1. A managed care organization shall offer or issue a health care plan to any person regardless of the health status of the person or any dependent of the person. Such health status includes, without limitation:*

(a) Any preexisting medical condition of the person, including, without limitation, any physical or mental illness;

(b) The claims history of the person, including, without limitation, any prior health care services received by the person;

(c) Genetic information relating to the person; and

(d) Any increased risk for illness, injury or any other medical condition of the person, including, without limitation, any medical condition caused by an act of domestic violence.

2. A managed care organization that offers or issues a health care plan shall not:

(a) Deny, limit or exclude a benefit based on the health status of an insured; or

(b) Require an insured, as a condition of enrollment or renewal, to pay a premium, deductible, copay or coinsurance based on his or her health status which is greater than the premium, deductible, copay or coinsurance charged to a similarly situated insured or the covered dependent of such an insured who does not have such a health status.

3. A managed care organization that offers or issues a health care plan shall not adjust a premium, deductible, copay or coinsurance for any insured on the basis of genetic information relating to the insured or the covered dependent of the insured.

Sec. 84. *1. A managed care organization that offers or issues a health care plan which provides coverage for dependent children shall continue to make such coverage available for an adult child of an insured until such child reaches 26 years of age.*

2. Nothing in this section shall be construed as requiring a managed care organization to make coverage available for a dependent of an adult child of an insured.

Sec. 84.5. *1. Except as otherwise provided in subsection 7, a managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Up to a 12-month supply, per prescription, of any type of drug for contraception or its therapeutic equivalent which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration;

(3) Listed in subsection 10; and

(4) Dispensed in accordance with section 11.3 of this act;

(b) Any type of device for contraception which is:

(1) Lawfully prescribed or ordered;

(2) Approved by the Food and Drug Administration; and

(3) Listed in subsection 10;

(c) Insertion of a device for contraception or removal of such a device if the device was inserted while the insured was covered by the same health care plan;

(d) Education and counseling relating to the initiation of the use of contraception and any necessary follow-up after initiating such use;

(e) Management of side effects relating to contraception; and

(f) Voluntary sterilization for women.

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. If a covered therapeutic equivalent listed in subsection 1 is not available or a provider of health care deems a covered therapeutic equivalent to be medically inappropriate, an alternate therapeutic equivalent prescribed by a provider of health care must be covered by the managed care organization.

4. Except as otherwise provided in subsections 8, 9 and 11, a managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition for coverage to obtain any benefit included in the plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use any such benefit;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

5. Coverage pursuant to this section for the covered dependent of an insured must be the same as for the insured.

6. Except as otherwise provided in subsection 7, a health care plan subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the plan or the renewal which is in conflict with this section is void.

7. A managed care organization that offers or issues a health care plan and which is affiliated with a religious organization is not required to provide the coverage required by subsection 1 if the managed care organization objects on religious grounds. Such a managed care organization shall, before the issuance of a health care plan and before the renewal of such a plan, provide to the prospective insured written notice of the coverage that the managed care organization refuses to provide pursuant to this subsection.

8. A managed care organization may require an insured to pay a higher deductible, copayment or coinsurance for a drug for contraception if the insured refuses to accept a therapeutic equivalent of the drug.

9. For each of the 18 methods of contraception listed in subsection 10 that have been approved by the Food and Drug Administration, a health care plan must include at least one drug or device for contraception within each method for which no deductible, copayment or coinsurance may be charged to the insured, but the managed care organization may charge a deductible, copayment or coinsurance for any other drug or device that provides the same method of contraception.

10. The following 18 methods of contraception must be covered pursuant to this section:

(a) Voluntary sterilization for women;

(b) Surgical sterilization implants for women;

(c) Implantable rods;

(d) Copper-based intrauterine devices;

(e) Progesterone-based intrauterine devices;

(f) Injections;

(g) Combined estrogen- and progestin-based drugs;

(h) Progestin-based drugs;

(i) Extended- or continuous-regimen drugs;

(j) Estrogen- and progestin-based patches;

(k) Vaginal contraceptive rings;

(l) Diaphragms with spermicide;

(m) Sponges with spermicide;

(n) Cervical caps with spermicide;

(o) Female condoms;

(p) Spermicide;

(q) Combined estrogen- and progestin-based drugs for emergency contraception or progestin-based drugs for emergency contraception; and

(r) Ulipristal acetate for emergency contraception.

11. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

12. A managed care organization shall not use medical management techniques to require an insured to use a different method of contraception other than the method prescribed or ordered by a provider of health care.

13. A managed care organization must provide an accessible, transparent and expedited process which is not unduly burdensome by which an insured, or the authorized representative of the insured, may request an exception relating to any medical management technique used by the managed care organization to obtain any benefit required by this section without a higher deductible, copayment or coinsurance.

14. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

(d) "Therapeutic equivalent" means a drug which:

(1) Contains an identical amount of the same active ingredients in the same dosage and method of administration as another drug;

(2) Is expected to have the same clinical effect when administered to a patient pursuant to a prescription or order as another drug; and

(3) Meets any other criteria required by the Food and Drug Administration for classification as a therapeutic equivalent.

Sec. 85. *1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Counseling and support for breastfeeding, including breastfeeding equipment, counseling and education during the antenatal, perinatal and postpartum period for not more than 1 year;

(b) Screening and counseling for interpersonal and domestic violence for women at least annually, with initial intervention services consisting of education, strategies to reduce harm, supportive services or a referral for any other appropriate services;

(c) Behavioral counseling concerning sexually transmitted diseases from a provider of health care for sexually active women who are at increased risk for such diseases;

(d) Such prenatal screenings and tests as recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(e) Screening for blood pressure abnormalities and diabetes, including gestational diabetes, after at least 24 weeks of gestation or as ordered by a provider of health care;

(f) Screening for cervical cancer at such intervals as are recommended by the American College of Obstetricians and Gynecologists or its successor organization;

(g) Such well-woman preventive visits as recommended by the Health Resources and Services Administration, which must include at least one such visit per year beginning at 14 years of age;

(h) A daily dose of 0.4 to 0.8 milligrams of folic acid for women who are capable of becoming pregnant;

(i) Aspirin for the prevention of preeclampsia for women who are determined to be at a high risk of that condition after 12 weeks of gestation;

(j) Medication to prevent breast cancer for women who are at a high risk of developing breast cancer and have a low risk of adverse side effects from the medication; and

(k) Prophylactic ocular tubal medication for the prevention of gonococcal ophthalmia in newborns.

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical

evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 86. *1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Counseling relating to the dietary needs of adults who are at a high risk of chronic diseases;

(b) Statin preventive medication for persons between the ages of 40 and 75 years who do not have a history of cardiovascular disease, but who have:

(1) One or more risk factors for cardiovascular disease; and

(2) A calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years;

(c) Aspirin for persons between the ages of 50 and 59 years who have a calculated risk of at least 10 percent of acquiring cardiovascular disease within the next 10 years and a life expectancy of at least 10 years;

(d) Vitamin D supplements for persons who are at least 65 years of age to prevent the person from falling if the person:

(1) Does not reside in a medical facility or a facility for the dependent; and

(2) Has an increased risk of falls;

(e) Tuberculosis screenings for latent tuberculosis infection in persons with increased risk of contracting tuberculosis;

(f) Screening for high blood pressure to confirm a diagnosis made outside a clinical setting before treatment is commenced;

(g) One abdominal aortic screening by ultrasound to detect abdominal aortic aneurisms for men between the ages of 65 and 75 years who have smoked during their lifetimes;

(h) Screening for hepatitis B infection for persons who are at a high risk of contracting hepatitis B;

(i) Screening for hepatitis C infection for persons who are at a high risk of contracting hepatitis C;

(j) One screening for hepatitis C infection for persons born between 1945 and 1965;

(k) Screening for osteoporosis for women who:

(1) Are 65 years of age and older; or

(2) Have a risk of fracturing a bone equal to or greater than that of a woman who is 65 years of age without any additional risk factors;

(l) Screening for alcohol misuse for persons 18 years of age or older;

(m) If a person engages in risky or hazardous consumption of alcohol, as determined by the screening described in paragraph (l), behavioral counseling to reduce such behavior; and

(n) Screening for lung cancer using low-dose computed tomography for persons between the ages of 55 and 80 years who:

(1) Have a smoking history of 30 pack-years;

(2) Smoke or have stopped smoking within the immediately preceding 15 years; and

(3) Do not suffer from a health problem that substantially limits the life expectancy of the person or the willingness of the person to undergo curative surgery.

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Computed tomography" means the process of producing sectional and three-dimensional images using external ionizing radiation.

(b) "Facility for the dependent" has the meaning ascribed to it in NRS 449.0045.

(c) "Medical facility" has the meaning ascribed to it in NRS 449.0151.

(d) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(e) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(f) "Pack-year" means the product of the number of packs of cigarettes smoked per day and the number of years that the person has smoked.

(g) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 87. *1. A managed care organization that offers or issues a health care plan shall include in the plan coverage for:*

(a) Screening for depression;

(b) All vaccinations recommended by the Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention of the United States Department of Health and Human Services or its successor organization;

(c) Screening, tests and counseling for such other health conditions and diseases as recommended by the Health Resources and Services Administration for persons less than 18 years of age; and

(d) Assessments relating to height, weight, body mass index and medical history for persons less than 18 years of age.

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management

techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 88. *1. Except as otherwise provided in this subsection, an evidence of coverage issued pursuant to this chapter may not restrict benefits for any length of stay in a hospital in connection with childbirth for a mother or newborn infant covered by the health care plan to:*

(a) Less than 48 hours after a normal vaginal delivery; and

(b) Less than 96 hours after a cesarean section.

➥ If a different length of stay is provided in the guidelines established by the American College of Obstetricians and Gynecologists, or its successor organization, and the American Academy of Pediatrics, or its successor organization, the health care plan may follow such guidelines in lieu of following the length of stay set forth above. The provisions of this subsection do not apply to any health care plan in any case in which the decision to discharge the mother or newborn infant before the expiration of the minimum length of stay set forth in this subsection is made by the attending physician of the mother or newborn infant.

2. Nothing in this section requires a mother to:

(a) Deliver her baby in a hospital; or

(b) Stay in a hospital for a fixed period following the birth of her child.

3. A health care plan may not:

(a) Deny a mother or her newborn infant coverage or continued coverage under the terms of the plan or coverage if the sole purpose of the denial of coverage or continued coverage is to avoid the requirements of this section;

(b) Provide monetary payments or rebates to a mother to encourage her to accept less than the minimum protection available pursuant to this section;

(c) Penalize, or otherwise reduce or limit, the reimbursement of an attending provider of health care because the attending provider of health care provided care to a mother or newborn infant in accordance with the provisions of this section;

(d) Provide incentives of any kind to an attending physician to induce the attending physician to provide care to a mother or newborn infant in a manner that is inconsistent with the provisions of this section; or

(e) Except as otherwise provided in subsection 4, restrict benefits for any portion of a hospital stay required pursuant to the provisions of this section in a manner that is less favorable than the benefits provided for any preceding portion of that stay.

4. Nothing in this section:

(a) Prohibits a health care plan from imposing a deductible, coinsurance or other mechanism for sharing costs relating to benefits for hospital stays in connection with childbirth for a mother or newborn child covered by the plan, except that such coinsurance or other mechanism for sharing costs for any portion of a hospital stay required by this section may not be greater than the coinsurance or other mechanism for any preceding portion of that stay.

(b) Prohibits an arrangement for payment between a managed care organization and a provider of health care that uses capitation or other financial incentives, if the arrangement is designed to provide services efficiently and consistently in the best interest of the mother and her newborn infant.

(c) Prevents a managed care organization from negotiating with a provider of health care concerning the level and type of reimbursement to be provided in accordance with this section.

5. An evidence of coverage subject to the provisions of this chapter that is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

6. As used in this section, "provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 89. *1. A managed care organization which offers or issues a health care plan must provide coverage for benefits payable for expenses incurred for:*

(a) A mammogram every 2 years, or annually if ordered by a provider of health care, for women 40 years of age or older;

(b) Counseling concerning genetic testing for breast cancer for women who are at a high risk of developing breast cancer; and

(c) Counseling concerning breast cancer chemoprevention for women who are at risk of developing breast cancer.

2. A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.

3. Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan shall not:

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. An evidence of coverage subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after January 1, 2018, has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal which is in conflict with this section is void.

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or

prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(b) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(c) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 90. NRS 695G.171 is hereby amended to read as follows:

695G.171 1. A health care plan issued by a managed care organization must provide coverage for benefits payable for expenses incurred for ~~[administering]~~ ***:***

(a) Deoxyribonucleic acid testing for high-risk strains of the human papillomavirus every 3 years for women 30 years of age or older; and

(b) Administering the human papillomavirus vaccine as recommended for vaccination by a competent authority, including, without limitation, the Centers for Disease Control and Prevention of the United States Department of Health and Human Services, the Food and Drug Administration or the manufacturer of the vaccine.

2. ~~[A health care plan must not require an insured to obtain prior authorization for any service provided pursuant to subsection 1.]~~ ***A managed care organization must ensure that the benefits required by subsection 1 are made available to an insured through a provider of health care who participates in the network plan of the managed care organization.***

3. ***Except as otherwise provided in subsection 5, a managed care organization that offers or issues a health care plan shall not:***

(a) Require an insured to pay a higher deductible, any copayment or coinsurance or require a longer waiting period or other condition to obtain any benefit provided in the health care plan pursuant to subsection 1;

(b) Refuse to issue a health care plan or cancel a health care plan solely because the person applying for or covered by the plan uses or may use a benefit provided in the health care plan pursuant to subsection 1;

(c) Offer or pay any type of material inducement or financial incentive to an insured to discourage the insured from obtaining any such benefit;

(d) Penalize a provider of health care who provides any such benefit to an insured, including, without limitation, reducing the reimbursement of the provider of health care;

(e) Offer or pay any type of material inducement, bonus or other financial incentive to a provider of health care to deny, reduce, withhold, limit or delay access to any such benefit to an insured; or

(f) Impose any other restrictions or delays on the access of an insured to any such benefit.

4. An evidence of coverage for a health care plan subject to the provisions of this chapter which is delivered, issued for delivery or renewed on or after ~~[July 1, 2007,]~~ ***January 1, 2018,*** has the legal effect of including the coverage required by subsection 1, and any provision of the evidence of coverage or the renewal thereof which is in conflict with ~~[subsection 1]~~ ***this section*** is void.

~~[4. For the purposes of this section, "human~~]

5. Except as otherwise provided in this section and federal law, a managed care organization may use medical management techniques, including, without limitation, any available clinical evidence, to determine the frequency of or treatment relating to any benefit required by this section or the type of provider of health care to use for such treatment.

6. As used in this section:

(a) "Human papillomavirus vaccine" means the Quadrivalent Human Papillomavirus Recombinant Vaccine or its successor which is approved by the Food and Drug Administration for the prevention of human papillomavirus infection and cervical cancer.

(b) "Medical management technique" means a practice which is used to control the cost or utilization of health care services or prescription drug use. The term includes, without limitation, the use of step therapy, prior authorization or categorizing drugs and devices based on cost, type or method of administration.

(c) "Network plan" means a health care plan offered by a managed care organization under which the financing and delivery of medical care, including items and services paid for as medical care, are provided, in whole or in part, through a defined set of providers of health care under contract with the managed care organization. The term does not include an arrangement for the financing of premiums.

(d) "Provider of health care" has the meaning ascribed to it in NRS 629.031.

Sec. 91. (Deleted by amendment.)

Sec. 92. The provisions of NRS 354.599 do not apply to any additional expenses of a local government that are related to the provisions of this act.

Sec. 93. (Deleted by amendment.)

Sec. 94. NRS 689A.523, 689A.585, 689B.450, 689C.082, 695A.159 and 695F.480 are hereby repealed.

Sec. 95. This act becomes effective:

1. Upon passage and approval for the purposes of performing any preparatory administrative tasks that are necessary to carry out the provisions of this act; and

2. On January 1, 2018, for all other purposes.

LEADLINES OF REPEALED SECTIONS

689A.523 "Exclusion for a preexisting condition" defined.

689A.585 "Preexisting condition" defined.

689B.450 "Preexisting condition" defined.

689C.082 "Preexisting condition" defined.

695A.159 Society prohibited from restricting coverage of child based on preexisting condition when person who is eligible for group coverage adopts or assumes legal obligation for child.

695F.480 Organization prohibited from restricting coverage of child based on preexisting condition if person who is eligible for group coverage adopts or assumes legal obligation for child.

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